Washington
Health Benefit Exchange

DRAFT Enrollment & Payment Process Guide

Individual Market

September 10, 2012

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1. Introduction

1.1. Document Purpose

This Process Guide is intended to clarify the enrollment and payment business process expectations and the related transmission of information on HIPAA transactions between the Washington Health Benefit Exchange (HBE) system and its trading partners. HBE defines trading partners as covered entities that either submit or retrieve HIPAA batch transactions to and from the HBE System.

This Process Guide provides information about the 834 Enrollment and 820 Premium Payment that is specific to the HBE and its trading partners. This guide is intended for trading partner use in conjunction with the ASX X12N Health Insurance Exchange Implementation Guides listed below.

The ANSI ASC X12N Implementation Guides can be accessed at: http://www.x12.org/

ASC X12, chartered by the American National Standards Institute more than 30 years ago, develops and maintains EDI and CICA standards along with XML schemas which drive business processes globally. The diverse membership of ASC X12 includes technologists and business process experts, encompassing health care, insurance, transportation, finance, government, supply chain and other industries.

1.2. Intended Users

The Process Guide is intended for members of the enrollment, payment processing, and supporting technical staffs of trading partners who are responsible for electronic transaction/file exchanges.

1.3. Relationship to Implementation Guides

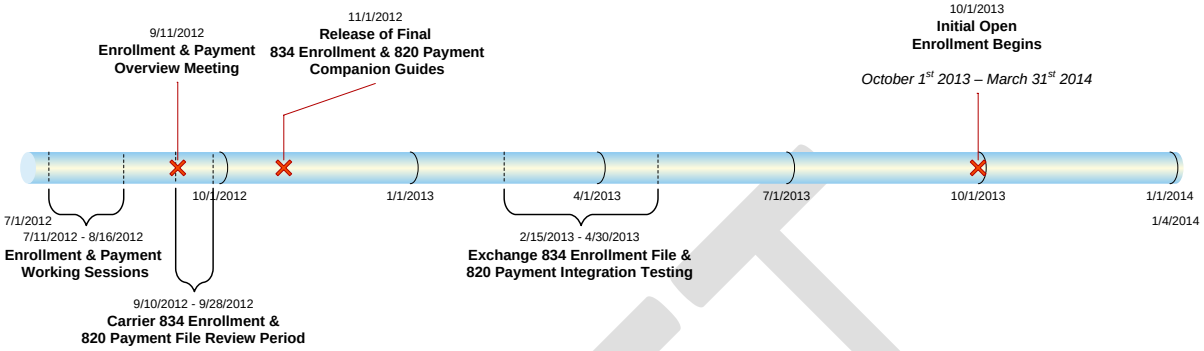
The Process Guide is intended to supplement rather than replace the standard Implementation Guides. Rules for format, content, and field values can be found in the Implementation Guides. The 834 Enrollment and 820 Payment formal Companion Guides will be released at a later date. This guide describes the technical interface environment with HBE, including connectivity requirements and protocols, and electronic interchange procedures. This guide also provides specific information on data elements and the values required for transactions sent to or received from HBE.

1.4. Washington Health Benefit Exchange Implementation Timeline

The HBE IT implementation timeline describes the planned design development and release of 834 Enrollment and 820 Payment Companion Guides and the corresponding details around the file transactions. The HBE will test file transactions from February 15, 2013 to April 30, 2013 with Carriers that plan to offer Qualified Health Plans in the HBE.

This testing will allow adequate time for any adjustments to be made prior to initial open enrollment beginning on October 1, 2013.

Washington Health Benefit Exchange
Implementation Timeline



2. Technical Infrastructure and Procedures

2.1. Technical Environment

2.1.1. Setup, HBE Contact Information

Trading partners can contact don.cotey@hca.wa.gov with technical questions.

2.1.2. Transport Protocols

The HBE will send and receive 834 and 820 Transactions using Secure File Transfer Protocol (SFTP).

The HBE is exploring Web Services as a transport mechanism.

2.1.3. Testing Process

Completion of the testing process must occur prior to production electronic retrieval from the HBE system. Testing is conducted to ensure transactions meet X12 guidelines.

2.2. Set-up, Directory, and File Naming Convention

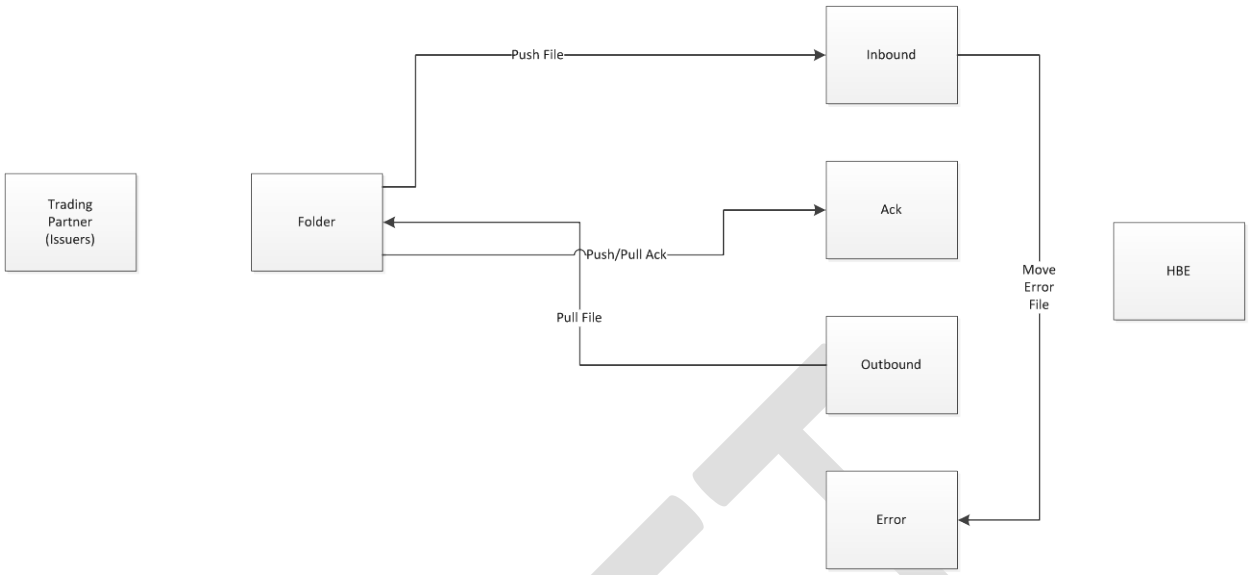
2.2.1. SFTP Directory Naming Convention

There would be two categories of folders under Trading Partner's SFPT folders:

1. TEST – Trading Partners should submit and receive their test files under this root folder
2. PROD – Trading Partners should submit and receive their production files under this root folder

The following folders will be available under the TEST/PROD folder within SFTP root of the Trading Partner:

- 'Inbound' - This folder should be used to drop the inbound files that needs to be submitted to HBE
- 'Ack' - Trading partner should look for acknowledgements to the files submitted in this folder. 999 and custom error reports will be available for all the files submitted by the Trading Partner
- 'Outbound' – X12 outbound transactions generated by HBE will be available in this folder
- 'Error' – Any inbound file that is not ASC X12 compliant or is not recognized by HBE will be moved to this folder



2.2.2. File Naming Convention

The following file naming conventions are used:

For Outbound transactions:

<TPId>.<market>.<QHPId>.<datetimestamp>.<TxID>.O
Example of file name: 165760000.I.1234.12262012211315.820.O

<TPId> is the Trading Partner Id

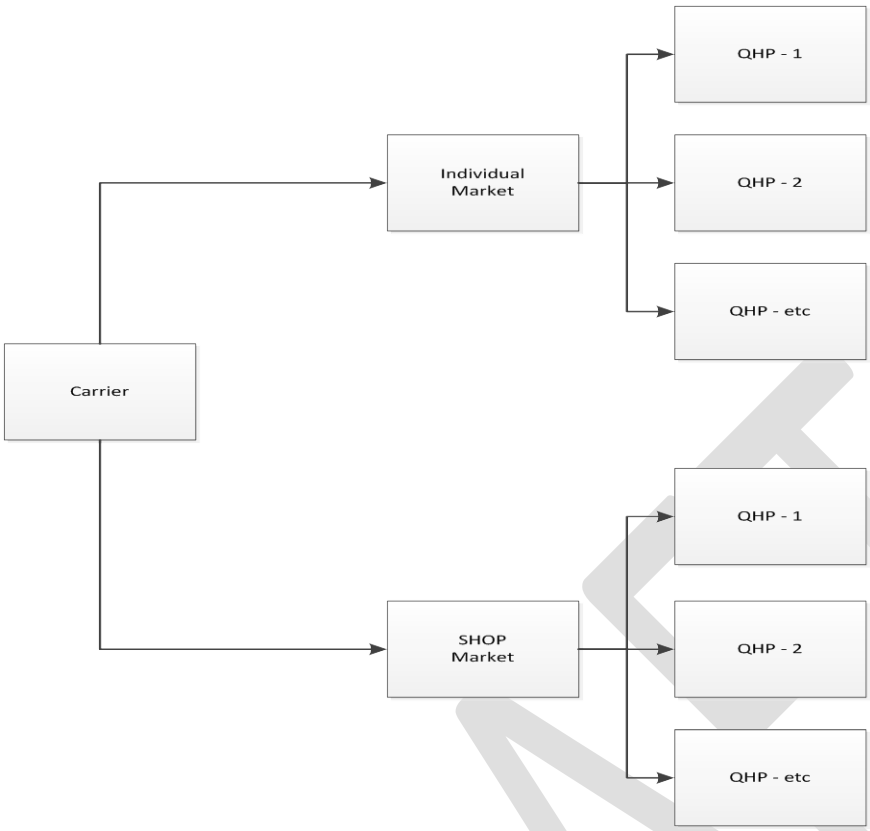
<Market> is "I" for the Individual market and "S" for the SHOP market

<QHPId> is the Qualified Health Plan Id

<datetimestamp> is the Date timestamp

<TxID> is the Transaction Id

<O> signifies outbound transaction



2.3. Transaction Standards

2.3.1. General Information

ASC X12 standards are specified in the Implementation Guide based on the August 2012 public review draft of the ASC X12 005010X306.

An overview of requirements specific to each transaction can be found in the 834 Enrollment and 820 Payment Implementation Guide. Implementation Guides contain information related to:

- Format and content of interchanges and functional groups
- Format and content of the header, detailer and trailer segments specific to the transaction
- Code sets and values authorized for use in the transaction
- Allowed exceptions to specific transaction requirements

2.3.2. Data Format

Delimiters

HBE recommends the ASC X12 standard delimiters:

- Data element separator, Asterisk, (*)
- Repetition Separator, Caret, (^)
- Component Element Separator, Colon, (:)
- Segment Terminator, Tilde, (~)

Dates

The following rules apply to any dates in the 834 Enrollment and 820 Payment transaction:

- For the 820 transaction, all dates will be formatted according to Year 2000 compliance, CCYYMMDD, except for the ISA09 element (Interchange date) where the date format is YYMMDD.
- The only value acceptable for "CC" (century) is 20. The exception to this rule is for any of the Date of Birth values.
- Time is in military time format, 1 to 24 to indicate hours and 00 to 59 to indicate minutes and/or seconds. ISA10 and GS05 elements are formatted HHMM.
- No spaces or character delimiters should be used in presenting dates or times.

Field Length

ASC X12 standards specify minimum and maximum field lengths for all of the data elements of the 834 Enrollment and 820 Payment transaction. The Transaction Specifications in Section 3 display the HBE field lengths.

Phone Numbers

Phone numbers are presented as contiguous number strings, without dashes or parenthesis markers. For example, the phone number (800) 555-1212 should be presented as 8005551212. Area codes should always be included.

2.3.3. Data Interchange Conventions

When transmitting 834 Enrollment and 820 Payment Transactions, HBE follows standards developed by the Accredited Standards Committee (ASC) of the American National Standards Institute (ANSI). These standards involve Interchange (ISA/IEA) and Functional Group (GS/GE) Segments or “outer envelopes”. All transactions are enclosed in transmission level ISA/IEA envelopes and, within transmissions, functional group level GS/GE envelopes. The segments and data elements used in outer envelopes are

documented in Appendix B1 of the 834 and 820 Implementation Guide. Specific information on how individual data elements are populated by HBE on ISA/IEA and GS/GE envelopes are shown in the table beginning later in this section.

2.3.4. **Acknowledgement Procedures**

The Exchange requires that Carriers send a response 999 Acknowledgement file for every inbound transaction received. The Exchange will not implement an 834 Effectuation File.

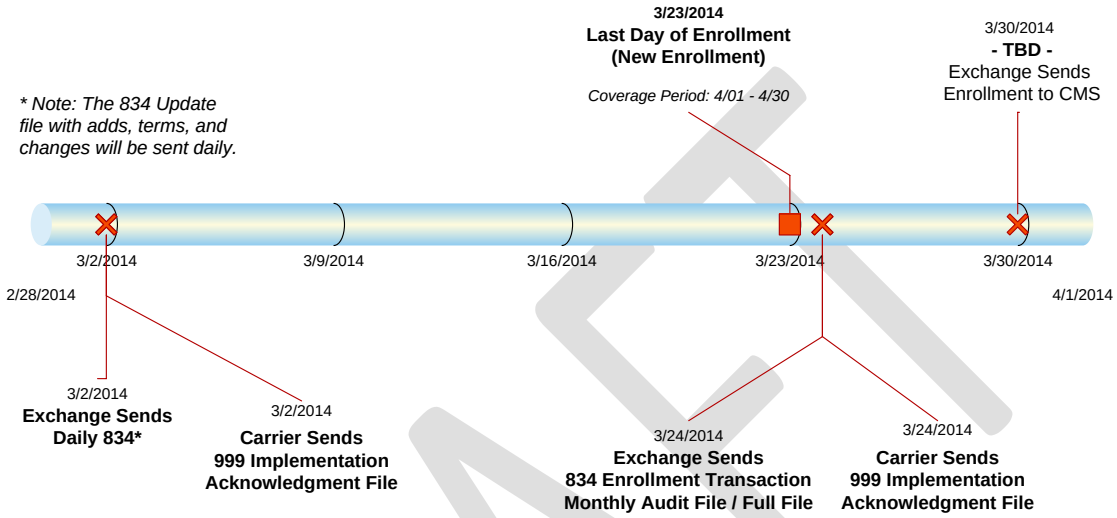
2.3.5. **Rejected Transmissions and Transactions**

HBE will validate all 834 and 820 transactions up to HIPAA validate levels 1 and 2. If a receiver rejects any part of a transmission, they must reject the entire transmission. Data on rejected 834 and 820 transmissions should not be used to update health plan databases.

3. Enrollment and Enrollment Transactions

3.1. Enrollment Calendar

Washington Health Benefit Exchange
Individual Market Enrollment Schedule



3.2. Enrollment Transmission Schedule

The Exchange will send a monthly 834 Enrollment Audit File to Carriers for each Qualified Health Plan. The Audit file will be sent on the first business day after the Enrollment Cutoff Date. The Exchange will send a daily 834 Update that includes adds, changes, and deletes.

The Exchange will send separate 834 Enrollment files for the individual market and the small group market.

3.3. Open Enrollment - Initial and Ongoing

The initial open enrollment period begins October 1, 2013 and extends through March 31, 2014. For effective coverage dates for initial open enrollment period on or before December 23, 2013, the coverage effective date will be January 1, 2014. Between (and including) the 1st and 23rd day of any subsequent month during the initial open enrollment period, the Exchange must ensure a coverage effective date of the first day of the following month; Between the 24th and last day of the month for any month between December 2013 and March 31, 2014, the coverage effective date will be the first day of the second following month.

For benefit years beginning on or after January 1, 2015, the annual open enrollment period begins October 15 and extends through December 7 of the preceding calendar year. Coverage is effective as of the first day of the following benefit year for a qualified individual who has made a QHP selection during the annual open enrollment period.

3.4. Eligibility

Individuals seeking health insurance coverage will complete a single statewide application. The HBE will offer individuals a seamless eligibility and enrollment process into QHPs and other public health insurance programs, such as Medicaid, Apple Health for Kids and the federal basic health program (if applicable). The HBE will use real-time eligibility determinations and allow for a single session enrollment process.

The HBE will be the system of record for all eligibility and demographic information. Any changes in demographic information will need to occur directly with the HBE. Any changes in eligibility will be reported to Carriers on the daily 834 Enrollment transaction.

3.5. Advance Premium Tax Credit (APTC) Enrollees

The HBE will make eligibility determinations for advance premium tax credits (APTC) and cost sharing reductions (CSR). Individuals and families with incomes between 100 percent and 400 percent of the federal poverty level may be eligible for APTC.[1] Individuals and families determined eligible for APTC will only receive the tax credit if they enroll in a QHP through the HBE.

The HBE will aggregate payments made directly to the Exchange, including individual payments and payments made by third party payers on behalf of the individual. The US Department of Health and Human Services will coordinate payments of the advance premium tax credits and cost sharing reductions directly with the Carriers.

3.6. Adds, Changes, and Disenrollments

3.6.1. **Adds**

For New Member Enrollment, an add event will be submitted through the daily 834 Enrollment File. For adds due to birth or adoption, see Section 4.2: Mid-month Enrollment and Disenrollment

For New Member Enrollment, Member's Effective Dates of Coverage will be as follows:

> For enrollment submitted between (and including) the 1st and the 23rd of the month, the coverage effective date will be the 1st of the following month.
>
> For enrollment submitted between (and including) the 24th and the end of the month, the coverage effective date will be the 1st of the second following month.

3.6.2. **Changes**

Change events will be submitted to change information like Last Name, First Name, SSN and Date of Birth, Gender, Marital Status and Address information. In the case of reporting

[1] Non-Citizens who are lawfully present and who are ineligible for Medicaid by reason of immigration status may be eligible for APTCs if their income is less than 100 percent of the federal poverty level.

multiple changes per individual, multiple records will be submitted and will not be consolidated into one record.

3.6.3. **Disenrollment**

Voluntary Disenrollment can occur when an enrollee chooses to initiate disenrollment through the Exchange web portal as a result of the enrollee obtaining other minimum essential or when an enrollee changes from one QHP to another during an annual open enrollment period or special enrollment period. The Disenrollment Date submitted on the 834 Transaction File will be the Last Date of Coverage for a Subscriber and/or Spouse or Dependent. For disenrollment due to a plan change for a reported birth or adoption special enrollment event, see Section 4.2: Mid-month Enrollment and Disenrollment

> Example: Subscriber is eligible on 8/31/2014 and no longer eligible on 9/1/2014 then the Termination Date will be entered as 20140831.

Involuntary Disenrollment can occur when an enrollee fails to make their premium payment in a timely manner. See "Grace Period and Delinquency Process" section.

In the case of fraudulent or incorrectly reported data, the Exchange may terminate an enrollee's coverage back to the effective date of coverage. Fraudulent or incorrectly reported data will be handled manually or through the reconciliation process. Details of this process are to be determined. We welcome feedback on this process through the comment process.

3.7 Reinstatement of Coverage

The Exchange will support reinstatement of health benefits during the annual Open Enrollment period or upon eligibility for a Special Enrollment period (See Section 4.1: Special Enrollment Events) if the enrollee has satisfied all payment in arrears through the current period. If the individual is not current on an outstanding payment, the individual will not be eligible for reinstatement of coverage through the Exchange. Some reinstatement eligibility determinations may be processed through a manual review from an internal Exchange team. This process is to be determined.

4. Special Enrollment

4.1. Special Enrollment Events

Individuals will report qualifying events through the Exchange web portal. A qualified individual has a 60 day Special Enrollment period from the date of the qualifying event to select a QHP. The Exchange will allow qualified individuals and enrollees to enroll in or change from one QHP to another as a result of the following triggering events:

1. A qualified individual or dependent loses minimum essential coverage (Note: This condition excludes loss of coverage due to non-payment of premiums);
2. A qualified individual gains a dependent or becomes a dependent through marriage, birth, adoption or placement for adoption;
3. An individual, who was not previously a citizen, national, or lawfully present individual gains such status;
4. A qualified individual's enrollment or non-enrollment in a QHP is unintentional, inadvertent, or erroneous and is the result of the Exchange or HHS error;
5. An enrollee adequately demonstrates to the Exchange that the QHP in which he or she is enrolled substantially violated a material provision of its contract in relation to the enrollee;
6. An individual is determined newly eligible or newly ineligible for advance payments of the premium tax credit or has a change in eligibility for cost-sharing reductions, regardless of whether such individual is already enrolled in a QHP.
7. A qualified individual or enrollee gains access to new QHPs as a result of a permanent move;
8. An Indian, as defined by section 4 of the Indian Health Care Improvement Act, may enroll in a QHP or change from one QHP to another one time per month; and
9. A qualified individual or enrollee demonstrates to the Exchange, in accordance with guidelines issued by HHS, that the individual meets other exceptional circumstances as the Exchange may provide.

In the case that a qualified individual elects to change from one QHP to another as a result of a qualifying event, the last day of coverage in the current QHP will be the last day of the first month prior to their coverage effective date in the new QHP.

4.2. Mid-month Enrollment and Disenrollment

The Exchange will support mid-month enrollment only in the case of a qualified individual gaining a dependent through birth or adoption. The effective date of coverage is the date of the qualifying event but not to exceed 60 days prior to the date that the event was reported.

In the case that the event was reported later than 60 days after the qualifying event, the individual will not be eligible for a special enrollment. In the case that an individual elects to change from one QHP to another as a result of a qualifying event, the effective end date of coverage in the current QHP will be the day prior to the qualifying event.

> Example 1: If the dependent of an enrollee is born on August 22nd, 2014 but the enrollee reports the qualifying event on September 12th, 2014, the effective date of coverage for the dependent will be August 22nd, 2014.

The Exchange will support mid-month terminations in the case of death. The effective end date of coverage will be the reported date of death.

Scenarios

Scenario 1: Mid-month Enrollment / Disenrollment -

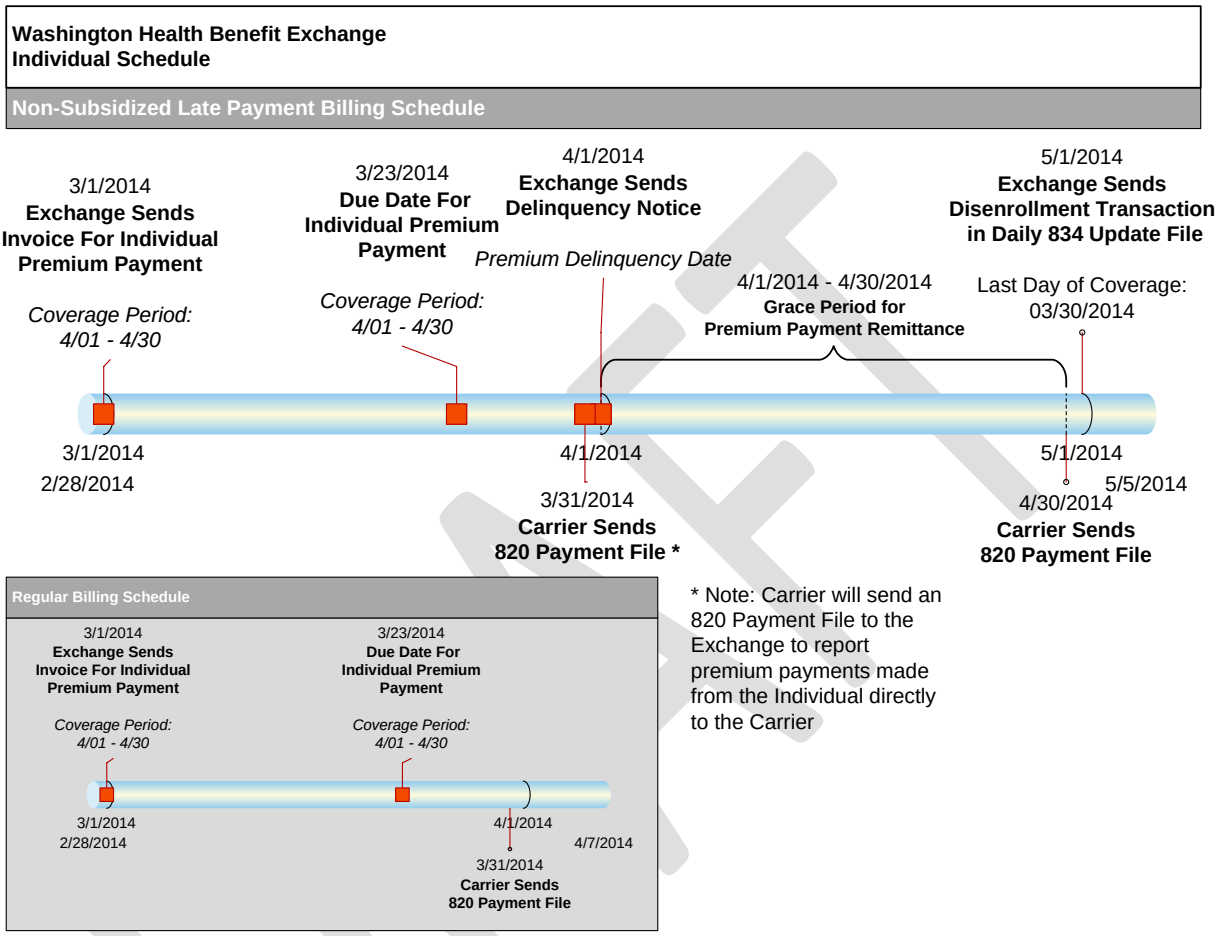
- Change Reported: Added an individual due to birth / adoption or individual removed due to death. Includes: Plan Change (e.g. QHP(a) to QHP(b)), Affordability Program to QHP (e.g. Medicaid to APTC QHP / non-subsidized QHP))

Table 1: Special enrollment effective dates for birth, adoption and death

Event Reported	Date of Event	Retroactive Enrollment Date	Retroactive Disenrollment Date	Special Enrollment of 60 days?	APTC Disenrollment applicable?
2nd	2nd	2nd	1st	Yes	Yes, 1st of next month
22nd	22nd	22nd	21st	Yes	Yes, 1st of next month
31st	31st	31st	30th	Yes	Yes, 1st of next month
> 60 days from event	Any day	No	No	No	Yes, 1st of next month

5. Enrollee Billing

5.1. Billing Calendar



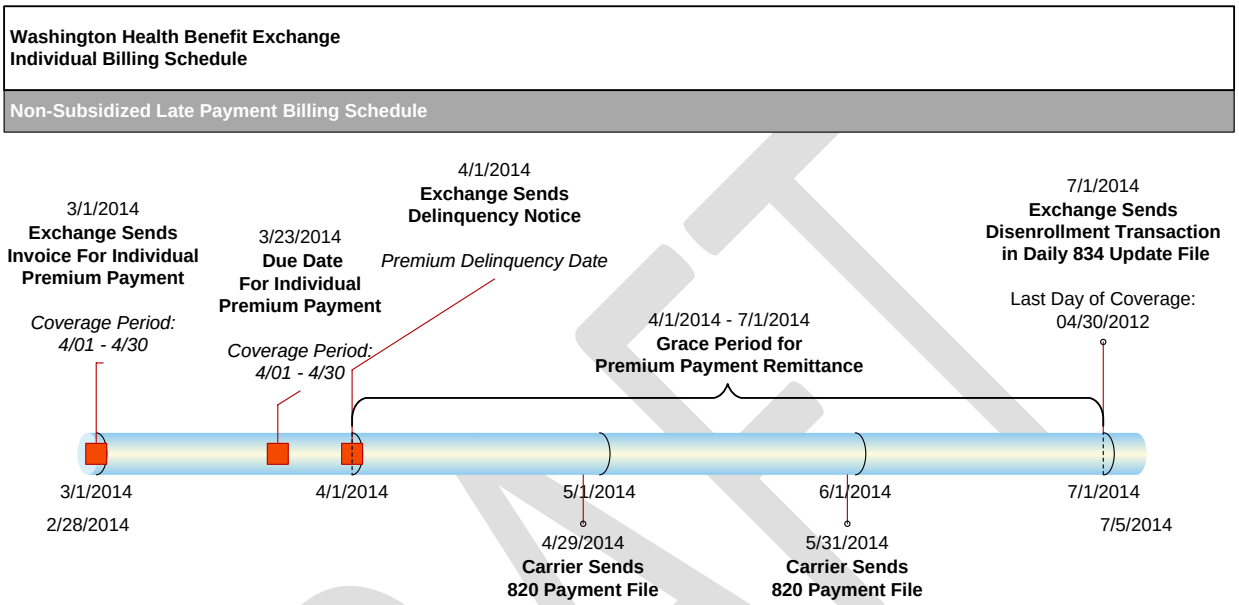
5.2. Premium Collection Schedule

The Exchange will invoice enrollees in the individual market on the 1st of the month prior to the month of coverage. For example, an invoice will be sent on March 1st for the April 1st -30th coverage period. The individual payment is due on the 23rd of each month, i.e. March 23 in this example.

5.3. Grace Period and Delinquency Process

The Exchange grants non-subsidized enrollees in the individual market a 30 day grace period beginning on the 1st of the month following a missed payment. The Exchange will send a Delinquency Notice to the enrollee on the 1st of the month following a missed payment. If the 30 day grace period for unsubsidized individuals has been exhausted, the last day of coverage will be the last day of the month prior to the 30 day grace period. A grace period can only be applied to enrollees who are current on their past month's premium payment and the Exchange will not allow consecutive or rolling grace periods.

Example: If payment is due on 03/23/2014 and no payment has been received, the enrollee has a 30 day grace period beginning 04/01/2014 to make payment for the prior month. On 04/30/2014 the premium payment for April and May is due in full. The enrollee will not be granted an additional grace period if the April and May premium payments are not satisfied by 04/30/2014.



The Exchange grants subsidized enrollees in the individual market a 90 day grace period beginning on the 1st of the month following a missed payment. The Exchange will send a Delinquency Notice to the enrollee on the 1st of the month following a missed payment. If the 90 day grace period for individuals receiving advance payment of the premium tax credit has been exhausted, the last day of coverage will be the last day of the first month of the 3-month grace period. The QHP will be expected to pay claims during the first month of a grace period, but may suspend claims in the second and third months.

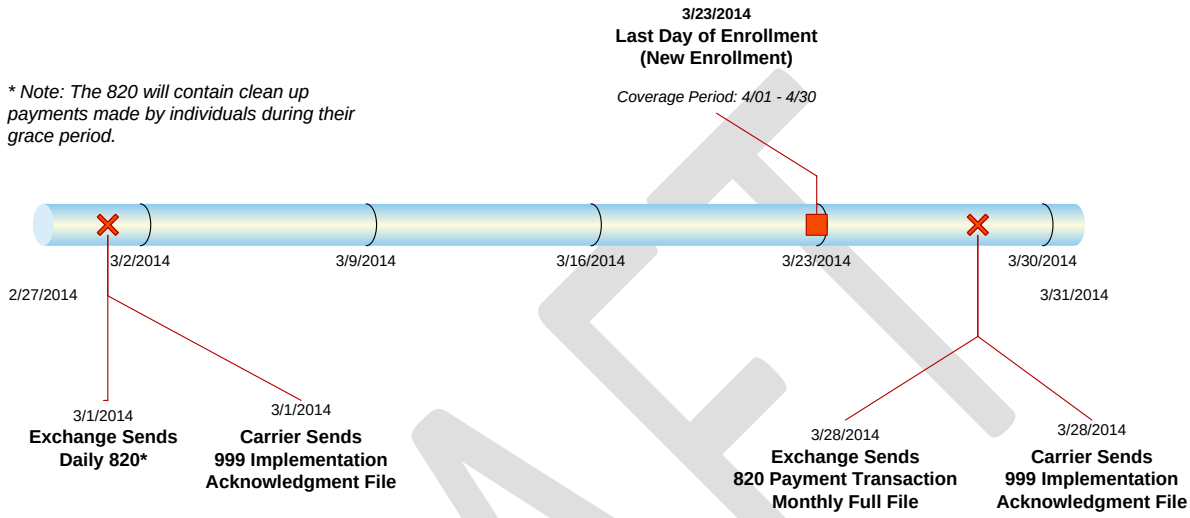
5.4 Carrier Receives Payment and Reports Payment to the Exchange

The Carrier will report premium payments made from the individual directly to the Carrier by sending the Exchange an electronic file of payments received by the end of the month. The format of this file is currently under development.

6. Payments

6.1. Payment Calendar

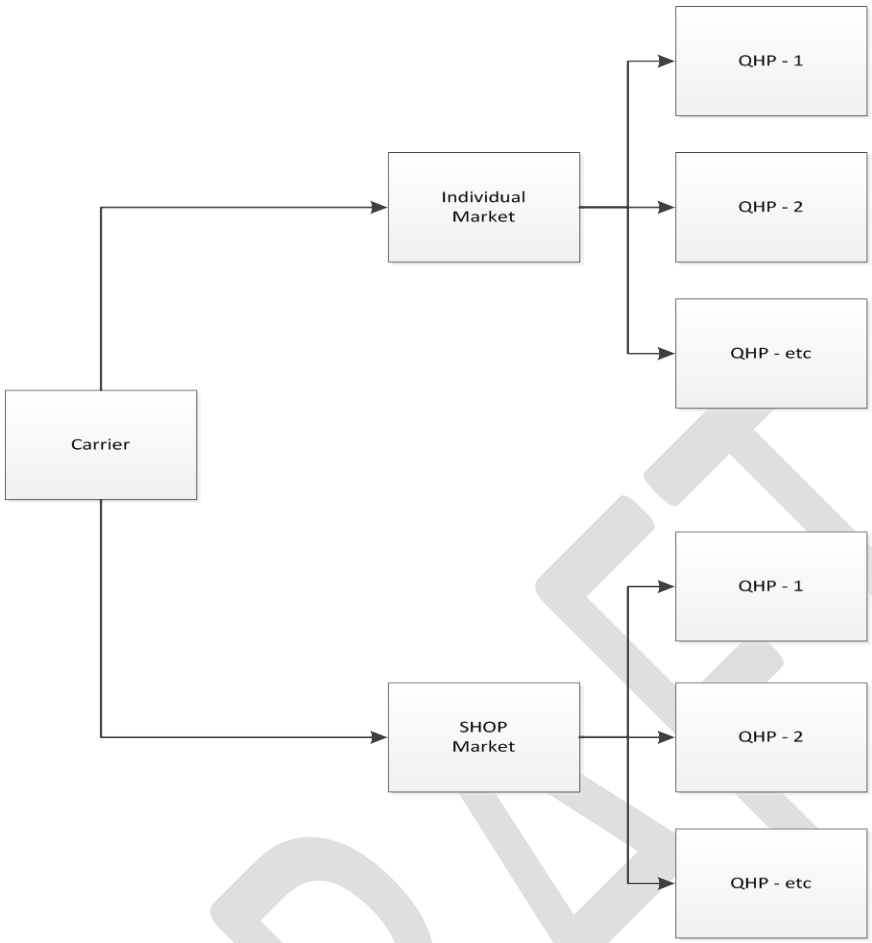
Washington Health Benefit Exchange
Individual Market Payment Schedule



6.2. Payment Transmission Schedule

The Exchange will collect and process premium payments from Individuals during open enrollment and on-going for monthly payments. The payments will be aggregated for Carriers and paid to Carriers once per month 5 business days after the Enrollment Cut-off Date for the following enrollment coverage period. An 820 ASC X12 file will be produced for each payment. Each Carrier will receive a separate 820 file for each Qualified Health Plan within the Individual and/or SHOP market.

The Exchange will collect and process daily premium payments past the cutoff date and provides 820 ASC X12 files to the Carriers.



6.3. Premium Payment to Carriers

The HBE will send the actual payment via EFT to the Carriers. The corresponding EFT identifying number will be sent in the 820.

6.4. APTC and CSR Payments

The 820 payment file will contain payments made directly to the Exchange and will include individual payments and payments made by third party payers on behalf of the individual. The US Department of Health and Human Services will coordinate payments of the advance premium tax credits and cost sharing reductions directly with the Carriers.

7. Reconciliation Process

7.1. Reconciliation Schedule

The HBE expects Carriers to perform a reconciliation on enrollment and payment data at least quarterly, but the Carrier may perform this function monthly, if desired.

7.2. Reconciliation Process

The monthly 834 Enrollment Audit File enables Carriers to systematically compare QHP enrollment data with HBE enrollment data and to identify discrepancies. The reconciliation process will allow the HBE and Carriers at a QHP level to identify potential member level enrollment data inconsistency.

The following types of discrepancies will be identified and reported:

- Member is reported as actively enrolled by HBE, but is not active with the QHP.
- Member is actively enrolled with QHP, but is not reported as active by HBE.
- Member coverage information differs between the QHP and the HBE (including date of birth, relationship code, plan type and address).
- Inconsistency in member enrollment and payment transactions

7.2.1. Reporting Enrollment Discrepancies

The detailed process for correcting incorrect enrollment data is being developed. The HBE and Carrier will work together to resolve any discrepancies. The HBE welcomes comments to develop a simple streamlined process for ensuring data in all systems is accurate and timely.

8. Transaction Specifications

8.1. 834 Enrollment Implementation Guide

The HBE is implementing the ASC X12 005010X306 version of the implementation guide. This version is currently under public review. The HBE will update this process guide when the approved version is released.

8.2. 820 Payment Implementation Guide

The HBE is implementing the ASC X12 005010X306 version of the implementation guide. This version is currently under public review. The HBE will update this process guide when the approved version is released.